CITY OF

ALBUQUERQUE

Employer-Sponsored Group Benefits

CONTRACT YEAR
July 1, 2007 - June 30, 2008

Table of Contents

This brochure is intended for summary purposes only. In all cases only the official plan documents control the administration and operation of the plans. Please be aware that some of the benefits listed in the various tables have limitations. See your Summary Plan Description (SPD) for more details. This brochure does not constitute a contract of employment nor does it change your employment-at-will status.

Your employer retains the right to modify benefits or premiums during annual contract negotiations to obtain benefits for employees.

CITY OF ALBUQUERQUE

MARTIN J. CHAVEZ, MAYOR

Dear Fellow Employees:

The City of Albuquerque is pleased to offer employees and their families one of the best insurance and benefits packages in New Mexico. The Human Resource Department's Insurance and Benefits staff has worked closely with our plans to design a package of quality benefits while keeping premiums down, despite significant and continued increases in medical costs.

This plan year, the City will continue to offer you a choice of two health plans that provide the same level of coverage, at premium rates well below the regional and national average. Presbyterian Health Plan will continue to offer the popular My Care Plan, which allows you to select an option that best suits your lifestyle and health care needs. CIGNA Health Plan will be offered again this year, providing very similar coverage while allowing you access to the Lovelace Hospitals and Physician networks.

Delta Dental Plan of New Mexico, United Concordia Dental, and Davis Vision are continuing to offer their products and services to City employees as sponsored plans this year, as well. Vision coverage will be available only through the Davis Vision Plan, which provides a more comprehensive vision care package. If you need vision care benefits, you must actively enroll with Davis Vision in order to have coverage.

One of the most underutilized City benefits is the Flexible Spending Account (Sec. 125) plan. To encourage your participation in this pre-tax program, the City will continue to pay the administrative fee associated with participation and will continue to offer the maximum deferral amount of $5,000 for both dependent care and medical expenses. For your added convenience, the City has approved the use of debit cards for this service. Information on the flexible spending debit card is included in this booklet.

Finally, participation in the parking and transit pre-tax plans (Sec. 132), which allow payment of transit and parking expense with pre-tax dollars, has been successful, and will continue to be offered this year. I encourage you to consider participating in this benefit if you pay to park or use mass transit to get to work.

If you have any questions about your benefits, the open enrollment process or any of the plans, please feel free to contact the Human Resources Department, Insurance and Benefits Division at 768-3758.

Best Wishes,

Martin J. Chavez, Mayor

Rules and Regulations - Guidelines for Enrollment

Welcome to the City of Albuquerque Employer Sponsored Group Benefits Plan
The City of Albuquerque and its Partnering Entities provide sponsored insurance benefits to their employees and the employee's eligible dependents, which include your legal spouse, children, children placed for adoption, domestic partners and domestic partner's children. This booklet summarizes benefits that are available to you and also provides information on participation criteria.

Your benefits enrollment is very important. We have prepared the following summary of information to assist you. It tells you who is eligible, what forms you will need to provide, and the importance of timely submission of your forms and documents. When in doubt, see your Benefits Specialist.

A. Who is eligible?

1. You, if you are in a permanent or permanent probationary status, an elected official or an unclassified employee and work at least 20 hours per week on a regular basis. (The qualifying hours and elected official eligibility may vary depending on your entity's policies. Please check with your Benefits Specialist).
2. Your Legal Spouse or Domestic Partner if you as the employee are eligible (see page 4).
3. Your unmarried natural or adopted children under age 25, if the child is dependant upon you for financial support
4. Your stepchildren or Domestic Partner's children, living with you and dependent upon you for support (unmarried and under limiting age).
5. Other children living with you for whom you have legal, court ordered custody or that have been placed for adoption by an accredited adoption agency or other legal authority (unmarried and under limiting age).
6. Coverage may be continued after limiting ages specified above for a child who is a dependent of the employee or the employee's spouse and who is physically or mentally incapacitated and is not eligible for coverage under any other plan or program if the condition occurred prior to age 25, subject to normal enrollment guidelines and approval by the medical insurance carrier.

B. Who isn't eligible?

1. Temporary employees
2. Seasonal employees
3. Employees under a limited term contract
4. Student employees
5. Ex-spouses, dependent children while in active military service, grandchildren, parents, aunts, uncles, brothers, sisters, nieces, nephews, married children, or anyone else unless they specifically meet the definitions above.

C. Member Responsibilities

1. Timely notification of Life Status Change events (see section L.)
2. Timely enrollment within 31 days of employment (no exceptions).
3. Timely submission of "Proof of Relationship" documents. Late documents are not accepted. They must be turned in when submitting enrollment forms.

D. General Enrollment Guidelines

1. **Once Medical, Dental or Vision coverage is selected, it cannot be cancelled or changed until the next open enrollment event unless you experience a Life Status Change.**
2. **Once enrolled in the vision plan, you may not drop this coverage until you and each of your covered dependents have been enrolled for two years even if you complete a cancellation form prior to the end of the two-year period.**
3. Enrollment is not subject to pre-existing condition exclusions, except for Long Term Disability coverage.
4. You must turn in enrollment forms and supporting documents together at the same time.

E. Levels of Coverage for Medical, Dental, and Vision plans.

1. ***Employee Only.*** You are enrolling for yourself only.
2. ***Employee and Spouse.*** You are enrolling for yourself and your eligible legal spouse.
3. ***Employee and Child(ren).*** You are enrolling for yourself and your eligible child(ren) only.
4. ***Family.*** You are enrolling for yourself, spouse, and eligible child(ren).
5. ***Employee and Domestic Partner.*** You are enrolling for yourself and your domestic partner only.
6. ***Employee, Domestic Partner, Child(ren).*** You are enrolling for yourself, your Domestic Partner and/or eligible child(ren).

F. No Double Coverage

1. If both you and your spouse work for the same employer, you may not enroll each other as an eligible spouse on any plan described in this booklet, nor may you both cover your children.
2. Double coverage outside the City of Albuquerque Employer Sponsored Group Benefits Plan is allowed.

G. Coordination of Benefits for Dental Plans

1. If both employees work for the same entity (even different departments or locations within that entity), **there will be no coordination of benefits between dental plans.**

2. If each employee works for different entities such as one employee works for the City of Albuquerque and one works for Sandoval County or an employer that does not participate in the City's benefits program, there will be coordination of benefits.
3. It is your responsibility to inform both dental carriers and your dentist in order to initiate benefits coordination.

H. Enrollment Events

1. You must enroll within 31 days of your first day of employment.
2. You may enroll during scheduled Annual Open Enrollment periods
3. You may enroll Under the Loss of Coverage Rule within 31 days of the loss of coverage.
4. You may enroll Under the provisions of the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**, there are two additional **special events** that may allow the employee to add health insurance coverage if an employee has not elected health insurance coverage during the initial eligibility period or during open enrollment. In order to add a health insurance plan for either of these special events, the employee must complete an enrollment form **within 31 days** of the event. The provisions of HIPAA apply only to health insurance.
   (1) If an employee has opted out of health insurance and then gets married, the employee may enroll in a health insurance plan and add the new spouse.
   (2) If an employee has opted out of health insurance and then a child is either born or adopted, the employee may add a health insurance plan and add the child.

I. Newly Eligible Dependents – Timing Is Everything

1. You must enroll newly eligible dependents within 31 days of the qualifying event. This includes new spouses, newborn children, adopted children, children placed for adoption, or children obtained through a court order of legal custody.
   (1) Failure to do so causes ineligibility and any incurred claims will be charged to the employee. You will also be required to wait until the next open enrollment event to enroll these dependents.

J. When Coverage Begins

1. Your coverage begins on the first day of the pay period after submission of enrollment forms and documents to your employer's benefits office or on the first day of work for newly hired employees who submit enrollment forms and documents on or before the first day of work.
2. Your coverage begins on July 1st when enrolling during annual Open Enrollment events.
3. Your coverage begins on the date of birth for newborns provided that enrollment forms and documents are submitted within 31 days of birth. Your premiums will be pro-rated back to the date of birth.
4. Your coverage begins on the first day of the pay period following the submission of enrollment forms and documents for all other newly eligible dependents or loss of coverage situations.

K. Eligibility Changes

1. You are responsible for reporting any eligibility changes and submitting enrollment forms and documents within 31 days of the change.
2. **YOU WILL BE RESPONSIBLE FOR COSTS INCURRED BY DEPENDENTS AFTER THEY BECOME INELIGIBLE.**

L. Examples of Life Status Change Events

1. New Employment
2. Marriage
3. New Baby (born or adopted)
4. Divorce
5. Involuntary Loss of Coverage
6. Dependent Child Turns 25 years old
7. Dependent Child Marries
8. Resignation, Retirement, or Termination of Employment

M. Home Address Changes

1. You are responsible to submit home address change information to your employer's Human Resources Department on the appropriate update form immediately after such changes.
2. Any notifications regarding benefits changes or other will be deemed to have been delivered to you when mailed to the address extracted from your employers HR information system.

N. Loss of Non-Employer Sponsored Health Care Coverage

1. If you and/or your dependent(s) are covered under another employer's sponsored health plan or other similar program, such as Medicaid, and such coverage is terminated through no fault of the insured, you and your eligible dependents may enroll in the health, dental, and vision plans within 31 days of the termination of other coverage.
2. This is subject to submission of enrollment forms, documents and proof of prior coverage and proof the coverage was lost.

O. Verification Procedures

1. All dependent information you record on the enrollment form is subject to verification.
2. You are required to display a registered marriage certificate when enrolling an eligible spouse.

3. You are required to display a State Issued and Recorded Birth Certificate when enrolling an eligible child.
4. Your employers benefits office will discuss Court Ordered benefits coverage and other related situations on a case-by-case basis.
5. During the course of the fiscal year, your employer may conduct a verification audit to assure dependent eligibility. Your employer will terminate any dependent from insurance coverage if you fail to submit required documents that prove eligibility.
6. Your employer will terminate all insurance coverage for you and your dependents if it is determined that enrollment forms and/or documents have been falsified in order to fraudulently obtain coverage. This may also be subject to legal and/or disciplinary action as may be determined by your employer.

P. Payment of Premiums

1. Your employer may offer a Pre-taxable Income Premium Plan (PIPP). Premium payments for active employees are deducted each pay period from the employee's payroll check for current coverage. Federal, State and FICA taxes are calculated after the health, dental, and vision premiums have been deducted, reducing your taxable income. This is also referred to as a Section 125 plan.

2. Premiums deducted in this manner cannot be used at year-end for tax purposes.

Q. Payment of Premiums when on an unpaid leave status

1. You are responsible for making premium payments to your employer's benefits office when you are in an "in-active" status and payroll deductions are not made. Such inactive status includes Workers Compensation, Disability, or any approved Leave Without Pay status.
2. See your Benefits Specialist to arrange for payment of premiums in this situation.
3. Failure to make premium payments will result in cancellation of insurance coverage.

R. Co-Payments

1. You are required to make the listed co-payments for health, dental, and vision services. They are due at the time of service.
2. Failure to make the required co-payment may result in services charges, balance billing, or termination of coverage by the plan provider.

S. Reinstatement Resulting From the Grievance Process

1. Employees who are reinstated to active employment as a result of the grievance process must contact their employer's Benefits Office with 31 days of reinstatement to arrange for re-enrolling in benefits coverage if the employee was participating in those benefits at the time of separation.
2. A copy of the re-instatement agreement must be provided and all other eligibility requirements apply.

T. COBRA CONTINUATION

1. The Comprehensive Omnibus Budget Reconciliation Act (**COBRA**) of 1985 provides for the continuation of health, dental, and vision insurance coverage for an eligible employee and eligible dependents due to a qualifying event that causes a loss of coverage.
2. A qualifying **COBRA** event is defined as a termination of employment (other than for gross misconduct); a reduction in hours of employment below the qualifying amount; a covered employees death; a divorce from a spouse who was the covered employee; a covered employee's entitlement to Medicare; a dependent child no longer satisfies the definition of a dependent child.
3. **COBRA** continuation of coverage may be available for 18 months in the event of termination or 36 months in the event of divorce, death, entitlement to Medicare, or the loss in dependent status.
4. All continuation of health, dental and vision coverage under **COBRA** legislation are subject to premium payments of 100% plus a 2% administrative fee. Coverage will terminate earlier than permitted by legislation if the participant becomes ineligible due to other coverage or if the participant fails to make premium payments. The covered employee or dependent is required to notify your Benefits Office of a divorce and/or child becoming ineligible within 31 days of this event. **COBRA** continuation may not be available if this notification is not received.

U. Annual Health Care Renewal

1. Your employer retains the right to modify the plan of benefits or premium structure during annual contract negotiations to obtain benefits for employees.
2. These modifications will be presented during an annual Open Enrollment period. Open Enrollment may consist of informational meetings and/or a packet of information sent to your mailing address of record.
3. Your Benefits office will schedule and conduct Open Enrollment.

V. Guaranteed Issue Requirements For Voluntary Life and Long Term Disability Insurance **(For those partnering entities that offer Voluntary Life and Long-Term Disability under the City of Albuquerque Employer Sponsored program)**

1. You must enroll within 31 days of employment for guaranteed issuance of coverage.
2. The guaranteed issue amounts for Voluntary Life Insurance are valid only if you enroll within 31 days of employment.
3. Late enrollment is allowed anytime after the initial 31 days of employment.
4. Medical underwriting will be required as determined by the plan carrier.

Extension of Benefits to Domestic Partners of Employees

A domestic partner is defined as a person of the same or opposite sex who live together in a long-term relationship of indefinite duration. There must be an exclusive mutual commitment similar to that of marriage, in which the partners agree to be financially responsible for each other's welfare and share financial obligations. These benefits are also available to the domestic partner's children provided that the child is primarily dependent upon the employee or domestic partner for support and a child/parent relationship exists.

To be recognized as domestic partners, both individuals must meet all of the following criteria, sign an Affidavit of Domestic Partnership and submit any necessary documentation.

Criteria:

1. Both partners must be unmarried.
2. Both partners reside in the same residence for at least 12 months and intend to do so indefinitely.
3. Must meet the age requirements for the State of New Mexico.
4. Must not be related by blood to the degree prohibited in a legal marriage in the State of New Mexico.
5. Must be financially responsible for each other's welfare and share financial obligations.

The Affidavit of Domestic Partnership and the submission of three of the following items will establish the financially responsible requirement.

a. a joint lease/mortgage - ownership
b. joint ownership of motor vehicle, joint bank account, or joint credit account (only one of these options will qualify)
c. domestic partner named as beneficiary of life insurance
d. domestic partner named as beneficiary of retirement benefits
e. domestic partner named as primary beneficiary in the employee's will
f. domestic partner assigned as power of attorney or legal designee
g. both partners share household expenses - this means both names are on the bill
h. domestic partner and employee have joint investment accounts

Coverage will begin on the first day of the pay period following the submission of the enrollment documentation (insurance forms, signed affidavit, three items establishing joint financial responsibility).

To terminate domestic partner benefits, an Affidavit of Termination must be completed. This will remove your domestic partner and domestic partner's children from the City's insurance coverages. Your domestic partner and his/her dependent children will be entitled to continuation of coverage under COBRA.

Under the Internal Revenue Code the value of employer-paid domestic partner benefits is taxable to the employee. This means the employee's cost for coverage will be deducted on an after-tax basis and the amount the Company contributes will, be subject to FICA and federal & state income tax.

Questions and Answers

When will coverage begin? During open enrollment, coverage begins on July 1st. For newly eligible employees with a domestic partner relationship, coverage begins on the first day of the pay period after submission of enrollment form and all required documentation.

Can I enroll my domestic partner's children? Yes, providing: 1) the employee and domestic partner meet the criteria, 2) the child is primarily dependent upon the employee or domestic partner for support and 3) a child/parent relationship exists based upon one of the following:

a. the employee/domestic partner is the biological parent of the child
b. either or both partners are adoptive parents of the child
c. the child has been placed in the partner's household as part of an adoptive placement, legal guardianship or by court order (excludes foster children)

How can I determine whether or not I will be subject to taxes on the domestic partners benefits? The key is to review your IRS 1040 Form to determine if you were able to claim your domestic partner and domestic partner's children on your personal federal tax return. If you were not able to declare the domestic partner or the children as dependents, **the benefits will be taxable.**

If I have recently entered into a relationship with a domestic partner, can I enroll now? No. You first must live together in the same residence for at least 12 months and intend to do so indefinitely.

What documentation is required? You will need to provide three (3) items showing mutual financial responsibility. Both you and the domestic partner will be required to complete an Affidavit of Domestic Partnership, and complete the necessary insurance forms. For dependents, please provide a copy of the birth certificate or copy of divorce decree stating you are responsible for the child's health coverage.

To enroll your domestic partner contact 505-768-3758 for an appointment.

Medical Plans

Plan Benefits

Each of the medical plan options provides comprehensive medical coverage for enrolled members. On the next pages you will find a general description of each of the plans, followed by a Benefits-At-A-Glance chart comparing key benefits of both plans. Finally, you will see a list of exclusions for items that neither of the plans cover.

In order to choose the plan that is right for you and your family, review the benefit levels for each plan, as well as the medical providers available to you.

Keep in mind this information is a summary only, and you should refer to each plan's official Summary Plan Description for full details, including all limitations and exclusions.

Learn More

You can find more information at **http://eweb.cabq.gov/**

Your Choices

You have the option to choose between two medical plans:

- Presbyterian Health Plan My Care Plan
- Cigna Open Access Plan

Cost of Coverage

No matter which plan you choose, your employer will pay a portion of the premium. The chart below shows your portion of the cost, which is taken on a per pay period basis. As you can see, your cost depends on the plan you choose as well as what family members you enroll.

Bi-Weekly Contributions		
	Presbyterian My Care Plan	**Cigna Open Access Plan**
Employee only	$24.09	$22.63
Employee and spouse	$49.01	$43.66
Employee and children	$38.69	$39.45
Employee and family	$70.73	$64.69

CIGNA HealthCare Open Access Plus Plan

for City of Albuquerque Employees

CIGNA HealthCare supports the City of Albuquerque and its employees in their quest for WELLNESS!

The Good News:

- Albuquerque was recently named the "fittest" city in the country by a leading fitness magazine!
- The Mayor has introduced residents to a "Fit City Challenge" to encourage continued physical activity and to support healthy lifestyles!

The Bad News*:

- Over 7% of New Mexicans have diabetes
- Over 30% of New Mexicans have high cholesterol
- Over 22% of New Mexicans have high blood pressure
- Over 21% of New Mexicans are current smokers
  - And many more people in our community are ***at risk*** of developing chronic conditions if they don't make important changes to their lifestyle NOW...

* Centers for Disease Control, BRFSS Prevalence Data 2005

The Solution:

CIGNA HealthCare is here to support City of Albuquerque employees, whatever their own health challenges may be. Whether you aim to manage your weight, improve your blood pressure, manage stress better, or just be a good role model for your children... CIGNA has tools for you!

We realize that each individual member and each unique family has specific needs when it comes to making healthy choices. CIGNA HealthCare offers unparalleled customization of tools and support to assist with these decisions. Our health professionals and online tools can help you gather information, set realistic goals, and take the steps you need to achieve success.

Log on to **www.mycigna.com** today to get started on improving YOUR quality of life!

myCIGNA.com

Turn to CIGNA for the Wellness Advantage

Visit myCIGNA.com or call Member Services to learn about the many programs and tools that can help guide you and your family to better health. You can also use myCIGNA.com to create a personal health profile that can offer steps for improvement and links to helpful resources.

We Can Help...

If you need inpatient surgery: Visit myCIGNA.com to learn how hospitals rank by number of procedures performed, average length of stay and cost.

If you want help improving your health and well-being: Call the toll-free number on your CIGNA HealthCare ID card and listen to programs on exercise, nutrition and weight control.

If you want to quit smoking: Healthy Rewards offers discounts on smoking cessation programs to help you reach you goal. You can also call the CIGNA HealthCare 24-Hour health Information Line℠ for tips to help you quit.

If your pregnancy may be putting your health – and the health of your baby-at risk: Our case managers can discuss your health risks and get you resources to help minimize those risks. We can provide information on a healthy pregnancy and give you phone access to registered nurses.

Online access to YOUR benefits and new resources at your personal, confidential portal. It's an easy and convenient way to manage your CIGNA HealthCare coverage. You can:

- Take an online questionnaire that can help you identify and monitor your health status
- Record and store personal health information in central, secure location
- Compare hospitals according to your unique needs and preferences
- Learn about and compare drug treatment options, and compare medications
- Get answers to frequently asked questions, verify benefits, order a new ID card, check claim status, and much more

Register today at **myCIGNA.com**

CIGNA HealthCare® Well Aware Program for Better Health®

You don't want a chronic illness to control your life. Now you have a resource to help you manage your chronic illness with personalized action plans and support. We have five separate programs:

- Asthma
- Diabetes
- Heart disease
- Low back pain
- Chronic obstructive pulmonary disease

Three New Well Aware Programs: Effective July 1, 2007

■ Weight Complications ■ Targeted Conditions ■ Depression

Call 1.877.888.3091 or visit **www.cigna.com** for more information about Well Aware.

CIGNA HealthCare 24-Hour Health Information Line℠

Registered nurses are available 24 hours a day, seven days a week with expert, reliable information to answer your health questions, help you find facilities and identify available options and treatments. In addition, there are hundreds of recorded audio programs in the Health Information Library.

Call 1.800.564.8982 for information about the Health Information Line.

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CIGNA HealthCare Healthy Rewards

Expand your health options at discounted prices. Through Healthy Rewards, you get access to a full range of health and wellness programs and services often not covered by traditional insurance plans.

Some examples:

- Weight Watchers®
- Jenny Craig weight loss
- CURVES
- QuitNet and Tobacco Solutions smoking cessation programs
- Chiropractic care and massage therapy
- Acupuncture
- Hearing aids and tests
- Anti-cavity products

Visit **myCIGNA.com** or call 1.800.870.3470 for more information on Healthy Rewards.

Tel-Drug/Pharmacy

- Home delivery of the medications you take regularly
- 24-hour ordering by mail, phone or online
- Free, prompt, confidential shipping
- Fast answers – Questions about medications, copayments or coverage? Just call us toll-free. We even offer 'round-the-clock urgent pharmacy services.
- It's a service of CIGNA HealthCare – We care about quality and safety! To try CIGNA Tel-Drug for your next prescription, call us toll-free to QuickSwitch® at 1.800.285.4812 (choose option #1) or visit our online Prescription Center at **www.teldrug.com**.

Choice and Convenience

CIGNA's Open Access Plus plan provides freedom & features you want

1. Comprehensive, In-Network coverage

The CIGNA HealthCare plan offers access to providers and hospitals in New Mexico and across the country through a vast, seamless network. In Albuquerque, members may access the Lovelace Health System (providers and facilities), University of NM and many Independent Provider practices. Including, many Behavioral HealthCare providers contracted by CIGNA Behavioral Health. You can find any provider by visiting **www.CIGNA.com**. Simply enter the name of the city or a zip code for a complete listing.

The plan does not require you to select a Primary Care Physician (PCP), members may seek care with any contracted provider. We encourage you to maintain a relationship with your PCP since he or she can be a valuable resource and personal health advocate.

When you visit a contracted provider (either a PCP or a Specialist) who is **in-network**, you will have the lowest out of pocket costs.

For example*:

- Coverage for preventive services (like routine physicals and well care)
- Pre-admission Certification and Prior Authorizations are obtained by in-network provider
- No claim forms
- $15 PCP office visit copay
- $25 specialist care office visit copay

Referrals are not required for Specialty care

2. Choice to visit Out-of-Network (non-contracted) providers

With out-of-network benefits, you can see any licensed provider you wish and still be covered for treatment of illnesses and injuries. You do not need to select a PCP or get referrals to see specialists. Keep in mind that the amount you pay out of your pocket will be higher if you choose a doctor who doesn't participate in our networks.

For example*:

- Pay 50% coinsurance, instead of copays
- Meet an annual deductible of $1,000
- File your own claim forms
- Pre-admission Certification for hospital stays and Prior Authorization for outpatient services may be required. You are responsible for making sure they are obtained.

* Refer to your summary plan description/benefit summary for full detail.

To find an In-Network provider, you can either visit **www.cigna.com** or refer to your CIGNA HealthCare Provider Directory.

For more information about services and benefits, call Member Services at 1.800.CIGNA 24 (244.6224).

PRESBYTERIAN Health Plan

Presbyterian Health Plan My Care Plan

With Presbyterian Health Plan's My Care Plan, employees can choose among three different benefit options to find a plan that best fits their unique needs: the Active, Family, and Independent options.

Once you select an option, you and your qualifying dependents will remain in that option until the next open enrollment. Each option is priced the same, and your per pay period contribution is the same for all options. The benefit levels vary as outlined below.

You choose from three benefit options

- Three options for coverage have been designed to accommodate different lifestyles
- You can choose the one that meets your needs
- Two options offer special reimbursements
- You don't need to select a Primary Care Physician (PCP) under any option

NEW for 2007! Preventive care copays are now eligible for reimbursement under your Unique Services Reimbursement Program. See your plan booklet for limitations and filing instructions.

The Active Option

The Active option is a good fit for individuals, couples, or some families who do not seek medical services often and are mainly concerned with preventive care. The Active option allows you to seek medical services from participating providers and offers a $150 reimbursement per family per contract year under the Unique Services Reimbursement Program for the following:

- Preventive care copays
- Gym memberships*
- Weight loss programs*
- Routine vision care
- Ambulance copays
- Copays for X-rays
- Sterilization services
- Smoking cessation
- Birth control pills
- LASIK surgery
- Vitamins*
- Dental treatment*

The Family Option

The Family option is great for those employees with a family-oriented lifestyle. These individuals typically have young children or are expecting to start a family. Instead of offering a Unique Service Reimbursement Program, this option offers significantly lower copayments for the services that children use most. Well-child care and preventive physical exams are only $5 for children enrolled on this plan and office visits are $10 for children.

The Independent Option

The Independent option is designed for individuals, couples, or families who want to visit doctors outside the Presbyterian network and receive coverage for those costs. This plan offers enhanced out-of-network coverage allowing you to visit providers outside of the Presbyterian Health Plan provider network. This option offers a $250 reimbursement per family per contract year under the Unique Services Reimbursement Program for the following:

- Preventive care copays
- Prescription drug costs with a physician's prescription
- Routine vision care
- Alternative therapies
- Disease management classes*
- Dental treatments*
- Diagnostic devices*
- Hearing aids

** If recommended by a physician to treat a specific medical condition. A note or prescription from the provider and the Unique Services Reimbursement Form must be submitted.*

All employees aren't the same, so why should their coverage be?

Employees of the City of Albuquerque and participating entities have the power of choice with Presbyterian's My Care plan. Employees are all very different and have different needs when it comes to their health care. With My Care, employees can choose between three different options (active, family and independent) in order to find the health plan that best fits their lifestyle. See your enrollment materials for more details and talk to your Presbyterian representative at open enrollment.

Health Plan

www.phs.org

PRESBYTERIAN

Medical Benefits At-A-Glance

The following is only a summary, some benefits may have further limitations or exclusions.

	CIGNA Open Access Plan		Presbyterian My Care[2]
	In-Network	**Out of Network**	**Active**
Annual deductible	None	$1,000 ind. $2,000 family	None
Annual out-of-pocket costs	$1,500 individual, $3,000 family	$3,000 ind. $6,000 family	Twice your annual premium
Lifetime maximum	Unlimited		Unlimited
Physician services			
Office visit	$15 co-pay per visit	50% after plan deductible[3]	$20 co-pay per visit
Specialist visit	$25 co-pay per visit		$30 co-pay per visit
Allergy testing	$25 co-pay per visit	50% after plan deductible	You pay 20%
Injections	$25 co-pay per visit, $15 co-pay if PCP	50% after plan deductible[3]	Included in office visit co-pay
Infertility services	$25 co-pay per visit, $15 co-pay if PCP	50% after plan deductible[3]	You pay 50%
Gynecological exam	$25 co-pay per visit, $15 co-pay if PCP	50% after plan deductible[3]	$20 co-pay
Pre and post natal care	$25 co-pay per initial visit, no charge for all other routine visits	50% after plan deductible[3]	$20 co-pay per visit up to $200 per pregnancy
Diagnostic X-ray			
MRI	$75 co-pay[1]	50% after $150 per procedure deductible and plan deductible[1 3]	$125 co-pay per test
Cat Scans	$75 co-pay[1]	50% after plan deductible[1 3]	$75 co-pay per test
Cardiac Cath	$150 co-pay[1]	50% after plan deductible[1 3]	$200 co-pay per test
X-Ray and Laboratory	No charge	50% after plan deductible[3]	No charge
Urgent care	$25 co-pay urgent, $15 co-pay non appointment care	50% after plan deductible[3]	Participating provider: $25 co-pay Non-participating provider: $50 co-pay
Emergency room	$75 co-pay,waived if admitted	50% after plan deductible[3]	$75 co-pay per visit, waived if admitted
Ambulance	No charge	50% after plan deductible[3]	$50 co-pay (ground), $100 co-pay (air)
Hospital			
Inpatient	$250 co-pay per admission[1]	50% after $500 per admit deductible and plan deductible[1 3]	$150 co-pay per day up to $450 per admission[1]
Outpatient	$150 co-pay[1]	50% after $250 per admit deductible and plan deductible[1 3]	$150 co-pay per visit[1]
Speech, physical, occupational therapy Outpatient	$20 co-pay per visit (60 visits per calendar year combined includes acupuncture)[1]	50% after plan deductible[1 3]	$30 co-pay per visit[1] (2 months per condition)
Acupuncture	See speech therapy	50% after plan deductible[3]	$30 co-pay per visit (20 visits per calendar year, medical necessity)
Durable medical equipment	No charge (up to $1,000 per calendar year)*[1]	50% after plan deductible[1 3]	You pay 50%[1]
Chiropractic	See speech therapy	50% after plan deductible[1 3]	$30 co-pay per visit (18 visits per calendar year, medical necessity)
Home Health Care	No charge (100 visits max per calendar year)*[1]	50% after plan deductible[1 3]	No charge[1]
Hospice	No charge[1]	50% after plan deductible[1 3]	$150 co-pay per day up to $450 per admission[1]
Skilled nursing care	No charge (60 days per calendar year)*[1]	50% after plan deductible[1 3]	$150 co-pay per day up to $450 per admission (60 days per calendar year) [1]
Dialysis	$150 co-pay per admission	50% after plan deductible[1 3]	You pay 20% per visit
Mental Health			
Inpatient	$250 co-pay per admission[1]	50% after $500 per admit deductible and plan deductible[1 3]	$150 co-pay per day up to $450 per admission[1]
Outpatient	$25 co-pay per visit	50% after plan deductible[3]	$30 co-pay per visit[1]
Substance Abuse			
Inpatient	$50 co-pay per day (30-day max per calendar year)*[1]	50% after $50 per day deductible and plan deductible[1 3]	Detox: $150 co-pay per day up to $450 per admission[1,3*] Rehab: 25% co-pay per admission[1,3*]
Outpatient	$25 co-pay for first 2 visits, $25 thereafter (20 visit max per calendar year)*	50% after plan deductible[3]	$30 co-pay per visit[1] (30 visits per calendar year)
Prescription drugs			
Retail	Generic $10, brand $35, non-preferred or brand name with generic equivalent 50%	In-network coverage only	Generic $10, brand $35, non-preferred $55 (30 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand, $10 plus difference in cost
Mail Order	Generic $20, brand $70, non-preferred or brand name with generic equivalent 50%	In-network coverage only	Generic $20, brand $87.50, non-preferred $165 (90 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand, $20 plus difference in cost

[1] Prior authorization/benefit certification applies.

[2] Pending Department of Insurance approval.

[3] Benefits are limited to reasonable and customary charges. You are responsible for any balance due above reasonable and customary charges.

For a more complete description please refer to each plan's member certificate, schedule of benefits or group subscriber agreement.

Presbyterian My Care[2]		
	Independent	
Family	**Network**	**Out-of-Network**
None	None	$500 individual, $1,500 family
Twice your annual premium	Twice your annual premium	$6,000 individual, $18,000 family
Unlimited	Unlimited	$2 million
$25 co-pay (adult), $10 co-pay (child)	$25 co-pay per visit	You pay 40%
$35 co-pay (adult), $20 co-pay (child)	$35 co-pay per visit	You pay 40%
You pay 20%	You pay 20%	You pay 40%
Included in office visit co-pay	Included in office visit co-pay	You pay 40%
You pay 50%	You pay 50%	Not covered
$25 co-pay (adult), $10 co-pay (child)	$25 co-pay	You pay 40%
$25 co-pay per visit up to $250 per pregnancy	$25 co-pay per visit up to $250 per pregnancy	You pay 40%
$200 co-pay per test (adult) $100 co-pay per test (child)	$125 co-pay per test	You pay 40%[1,4]
$125 co-pay per test (adult) $75 co-pay per test (child)	$75 co-pay per test	You pay 40%[1,4]
$300 co-pay per test (adult) $175 co-pay per test (child)	$200 co-pay per test	You pay 40%[1,4]
No charge	No charge	You pay 40%[1,4]
Participating provider: $35 co-pay (adult), $20 co-pay (child), Non-participating provider: $45 (adult), $30 co-pay (child)	$35 co-pay	$45 co-pay no deductible
$75 co-pay per visit, waived if admitted	$75 co-pay per visit, waived if admitted	$75 co-pay per visit no deductible
$50 co-pay (ground), $100 co-pay (air)	$50 co-pay (ground), $100 co-pay (air)	$50 co-pay (ground), $100 co-pay (air)
$150 co-pay per day up to $450 per admission (adult)[1] $100 co-pay per day up to $300 per admission (child)[1]	$150 co-pay per day up to $450 per admission[1]	You pay 40%[1, 4]
$200 co-pay per visit (adult), $100 co-pay per visit (child)[1]	$125 co-pay per visit[1]	You pay 40%[1, 4]
$35 co-pay per visit (adult), $20 co-pay per visit (child) (2 months per condition)	$35 co-pay per visit (2 months per condition)	You pay 40%[1, 4] (2 months per condition) Speech therapy not covered out-of-network
$35 co-pay (adult), $20 co-pay (child); (20 visits per calendar year, medical necessity)	$35 co-pay per visit (20 visits per calendar year, medical necessity)	You pay 40%
You pay 50%[1]	You pay 50%[1]	You pay 50%[1,4]
$35 co-pay (adult), $20 co-pay (child) (18 visits per calendar year, medical necessity)	$35 co-pay per visit (18 visits per calendar year, medical necessity)	You pay 40%
No charge[1]	No charge[1]	You pay 40%[1,4]
$150 co-pay per day up to $450 per admission (adult) $100 co-pay per day up to $300 per admission (child)[1]	$150 co-pay per day up to $450 per admission[1]	You pay 40%[1,4]
$150 co-pay per day up to $450 per admission (adult) $100 co-pay per day up to $300 per admission (child) (60 days per calendar year) [1]	$150 co-pay per day up to $450 per admission[1]	You pay 40%[1,4]
You pay 20% per visit	You pay 20% per visit	You pay 40%
$150 co-pay per day up to $450 per admission (adult)[1] $100 co-pay per day up to $300 per admission (child)[1]	$150 co-pay per day up to $450 per admission[1]	You pay 40%[1,4]
$35 co-pay (adult), $20 co-pay (child) per visit[1]	$35 co-pay per visit[1]	You pay 40%[1,4]
Detox: $150 co-pay per day up to $450 per admission (adult)[1]; $100 co-pay per day up to $300 per admission (child)[1]; Rehab: 25% co-pay per admission[1]*	Detox: $150 co-pay per day up to $450 per admission[1]; Rehab: 25% co-pay per admission[1,4] *	You pay 40%[1,4]
$35 co-pay per visit (adult)[1]; $20 co-pay per visit (child)[1] (30 visits per calendar year)	$35 co-pay per visit[1] (30 visits per calendar year)	You pay 40%[1,4]
Generic $10, brand $30, non-preferred $50 (30 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand $10 plus difference in cost	Generic $10, brand $30, non-preferred $50 (30 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand $10 plus difference in cost	Not covered unless an emergency outside service area (deductible doesn't apply)
Generic $20, brand $75, non-preferred $150 (90 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand $20 plus difference in cost	Generic $20, brand $75, non-preferred $150 (90 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand $20 plus difference in cost	Not covered

[4] A 15% penalty applies if benefit certification is not obtained.
*20 visits and 1 episode per calendar year, 3 episodes per lifetime.

Exclusions to Coverage for the Medical Plans

The following exclusions and limitations apply to both the CIGNA HealthCare and the Presbyterian Health Plan My Care medical plans. Items with a "*" may be eligible for reimbursements under the Presbyterian Health Plan Unique Services Reimbursement Program (See page 10 for a summary)

Any exclusion listed would not be applicable if Covered under FIT Program in accordance with that which is required under N.M.S.A.§ 59A-46-38.1. Refer to your Group Subscriber Agreement for details.

- Alternative/complementary therapies, except as specified in the Group Subscriber Agreement (GSA)*
- Any service, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be not medically necessary or accepted medical practice
- Artificial aids including speech synthesis devices except items identified in the Group Subscriber Agreement (GSA)
- Athletic trainers*
- Autopsies and/or transportation costs for deceased Members
- Baby food (including baby formula or breast milk) or other regular grocery products that can be blenderized for oral or tube feedings
- Benefits and services not specified as covered
- Biofeedback, except as specified in the Group Subscriber Agreement (GSA)
- Cancer Clinical Trials are limited to phase 2, 3 and 4 and must be provided for in the State of New Mexico in accordance with the provisions set forth in the Group Subscriber Agreement (GSA)
- Care for conditions which State or local law requires be treated in a public or correctional facility
- Care for military service connected disabilities to which the member is legally entitled and for which facilities are reasonably available to the member
- Charges that are determined to be unreasonable by the carrier
- Circumcisions performed other than during the newborn's hospital stay unless medically necessary
- Clothing or other protective devices including prescribed photoprotective clothing, windshield tinting, lighting fixtures and/or shields, and other items or devices whether by prescription or not
- Co-dependency treatment
- Convenience items
- Cosmetic surgery, treatments, devices, orthotics, and medications, including treatment of hair-loss
- Costs for extended warranties and premiums for other insurance coverage
- Counseling - sex, pastoral/spiritual, and bereavement counseling
- Court ordered evaluation or treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as alcohol or substance abuse programs and/or psychiatric evaluation or therapy
- Covered services obtained from a non-participating provider/practitioner, except as provided in the Group Subscriber Agreement (GSA) (Not applicable to the Presbyterian Independent option or to the services eligible for reimbursement under the Unique Services Reimbursement Program services)
- Custodial or domiciliary care - including but not limited to eating, bathing, dressing or other self care activities or homemaker services.
- Dental care and dental x-rays, except as provided in the Group Subscriber Agreement (GSA)*
- Dental implants*
- Disposable medical supplies, except when provided in a hospital or a physician's office or by a home health professional
- Donor sperm
- Exclusions related to covered durable medical equipment - additional wheelchairs, duplicate items, convenience items, upgraded or deluxe items, repair or replacement due to loss, neglect, misuse, abuse, to improve appearance, for convenience or items under the manufacturer or supplier's warranty
- Elastic support hose
- Elective abortions after the 24th week of pregnancy
- Elective Home Birth and any prenatal or postpartum services connected with an elective home birth
- Emergency facility used for non-emergent services
- Exercise equipment and videos, personal trainers, club memberships and weight reduction programs*
- Experimental/Investigational, as determined by the carriers, drugs, medicines, treatments or procedures
- Extracorporeal shock wave therapy involving the musculoskeletal system
- Eye movement therapy.
- Eye refractive procedures including radial keratotomy, laser procedures, and other techniques*
- Eyeglasses (Corrective) or sunglasses, frames, lens prescription, contact lenses or the fitting thereof except as provided in the Group Subscriber Agreement (GSA)*
- Foot care (routine), except as provided in the Group Subscriber Agreement (GSA)
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided
- Gloves, unless part of a wound treatment kit
- Hair-loss (or baldness) treatments, medications, supplies and devices including wigs, and special brushes
- Halfway houses
- Hearing aids and the evaluation for the fitting of hearing aids
- Home sleep studies
- Hospice benefits are not available for the following services: food, housing and delivered meals, volunteer services, comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those covered under durable medical equipment benefits), homemaker and housekeeping services, private duty nursing, pastoral and spiritual counseling or bereavement counseling
- Hypnotherapy except as part of anesthesia preparation or chronic pain
- Infant formula
- In-vitro, GIFT and ZIFT fertilization
- Lay midwife - Services of a lay midwife or an unlicensed midwife
- Malocclusion treatment, if part of routine dental care and orthodontics
- Massage therapy, unless performed by a licensed physical therapist and as part of a prescribed short-term physical therapy program
- Medical and hospital services of a donor when the recipient of an organ transplant is a not a member or when the transplant procedure is not covered
- New medications for which the determination of criteria for coverage has not yet been established by the carrier
- Nutritional supplements except as provided in the Group Subscriber Agreement (GSA)*
- Organ transplants (Non-human), except for porcine (pig) heart valve
- Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges, and dentures*
- Orthodontic appliances and orthodontic treatment, crowns, bridges, and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related*
- Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints except for patients with diabetes or other significant neuropathies
- Orthotics (functional foot), except as provided in the Group Subscriber Agreement (GSA) for patients with diabetes or other significant peripheral neuropathies
- Orthotics/orthosis (Custom Fabricated) except as specified in the Group Subscriber Agreement (GSA).
- Over-The-Counter (OTC) medications except as specified in the Group Subscriber Agreement (GSA).
- Personal or comfort items, services or treatments
- Photophoresis for all conditions other than mycosis fungoides
- Physical examinations, vaccinations, drugs and immunizations for the primary intent of medical research or non-medically necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related to employment
- Prescription drugs received upon hospital discharge, provided by a hospital pharmacy unless a participating outpatient pharmacy is not available*
- Prescription drugs requiring a benefit certification when benefit certification was not obtained*
- Prescription drugs ordered by a non-participating provider or purchased at a non-participating pharmacy unless required due to an emergency occurring outside of the service area*
- Prescription drug, compounded medications*
- Prescription drug replacements due to loss, theft, or destruction*
- Private duty nursing
- Psychological testing when not medically necessary
- Residential treatment centers unless for the treatment of alcoholism and/or substance abuse rehabilitation
- Reversals of voluntary sterilization - male or female
- Services for which the member is eligible under any governmental program (except Medicaid), or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the member or dependent
- Services requiring bcenefits certification when benefit certification was not obtained
- Sex transformation surgery and drugs relating to sex transformation
- Sexual dysfunction treatment, including medication, counseling, and clinics, except for penile prosthesis as provided in the Group Subscriber Agreement (GSA)
- Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances. Except as provided for under the Family, Infant and Toddler (FIT) Program. Refer to the Group Subscriber Agreement (GSA) for more information
- Special medical foods, except as listed as covered in the Group Subscriber Agreement (GSA) for Genetic Inborn Errors of Metabolism
- Storage or banking of sperm, ova (human eggs), embryos, zygotes, or other human tissue
- "Telephone visits and electronic mail (E-mail)" by a Physician or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient
- Transportation costs for deceased members
- Travel and lodging expense, except as provided in the Group Subscriber Agreement (GSA)
- Vision care (routine) and eye refractions for determining prescriptions for corrective lenses, except as listed as covered in the Group Subscriber Agreement (GSA)*
- Visual training
- Vocational rehabilitation services and long-term rehabilitation services
- Weight reduction or control treatments, except for medically necessary treatment for morbid obesity*
- Work-related accidents or injuries or occupational illness or disease if the member is required to be covered under workers' compensation insurance, whether or not such coverage actually exists

The following is also not covered by the CIGNA HealthCare plan:

- Repair or replacement of durable medical equipment, orthotic appliances and prosthetic devices due to normal wear, loss or damage.
- Private hospital rooms and/or private duty nursing except as provided in the Home Health Services as noted in the Group Service Agreement (GSA)
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.

The following is also not covered by the Presbyterian Health Plan My Care plan:

- Independent option - The following services are not covered on the out-of-network option: Organ transplants, infertility services, cardiac and pulmonary rehabilitation, covered mediations, prescription drugs, specialty pharmaceuticals and special medical foods.

The above is only a summary, some benefits may have further limitations or exclusions. For a more complete description please refer to each plan's member certificate, schedule of benefits or group subscriber agreement.

Dental Plans

Plan Benefits

Each of the dental plan options provides comprehensive dental coverage for enrolled members. On the next pages you will find a general description of each of the options, followed by a Benefits-At-A-Glance chart comparing key benefits of the plans.

In choosing a dental plan it is important to consider the types of services covered and the dental providers available to you. Benefits are based on four main classifications of services:

- **Diagnostic and Preventive** usually includes: cleanings, exams, X-rays, sealants and fluoride treatments
- **Basic** usually includes: fillings, root canals, periodontics, extractions, oral surgery and general anesthesia
- **Major** usually includes: crowns, bridges and dentures
- **Orthodontics** usually includes: diagnostic and retention treatment

Keep in mind this information is a summary only, and you should refer to each plan's official Summary Plan Description for full details, including all limitations and exclusions.

Learn More

You can find more information at **http://eweb.cabq.gov/**

Your Choices

You may choose to enroll yourself and your eligible dependents in one of two dental options:

- Delta Dental Plan of New Mexico
- United Concordia Flex (High Option)

Cost of Coverage

No matter which plan you choose, your employer will pay a portion of the premium. The chart below shows your portion of the cost, which is taken on a per pay period basis. As you can see, your cost depends on the plan you choose as well as what family members you enroll.

	Bi-Weekly Contributions	
	Delta Dental Plan	**United Concordia High Plan**
Employee only	$2.09	$1.97
Employee and spouse	$4.19	$4.20
Employee and children	$4.35	$4.34
Employee and family	$5.86	$5.86

DELTA DENTAL

Great Oral Health

Both sides of the Delta Dental plan feature national dental provider networks, with dentists in every state. This plan is all about choice, and a different network selection may be made each time treatment is desired. Pre-selection of a dentist is never required and every member of the family may use a different dentist.

Delta Dental PPO dentists have specifically agreed to reduced Maximum Approved Fees which result in lower charges for dental services. The dollar amount resulting from the patient co-payment percentage will be less when one of these dentists is selected. In addition, there is no co-payment for covered preventive care services received from a Delta Dental PPO dentist.

Because the Delta Dental PPO network does not include specialty dentists in every category, and because many enrollees already have established relationships with their dentists, Delta Dental Premier dentists may also be selected for any service. Delta Dental Premier is the nation's most extensive dental network, with over 121,000 independent participating providers.

Designed to give you and every member of your family the most choice in selecting your own dentists, both plans feature strong preventive care benefits that make getting, and keeping, good oral health easy and affordable.

Delta Dental PPO	Delta Dental Premier
• Over 180 points of access in the Albuquerque Metro area. • Over 95,000 dentist locations nationally, with dentists in all 50 states. • Features a fee schedule that can help make dental services more affordable and reduce out-of-pocket costs at the time services are received. • Preventive care covered at 100%.	• The broadest selection of dentists – over 360 points of access in the Albuquerque Metro area. • With over 171,000 dentist locations nationally, and dentists in all 50 states, Delta Dental Premier is the nation's most extensive dental network. Featuring over 860 Points of Access around the state, more than 90% of the dentists in New Mexico participate in Delta Dental Premier.

United Concordia

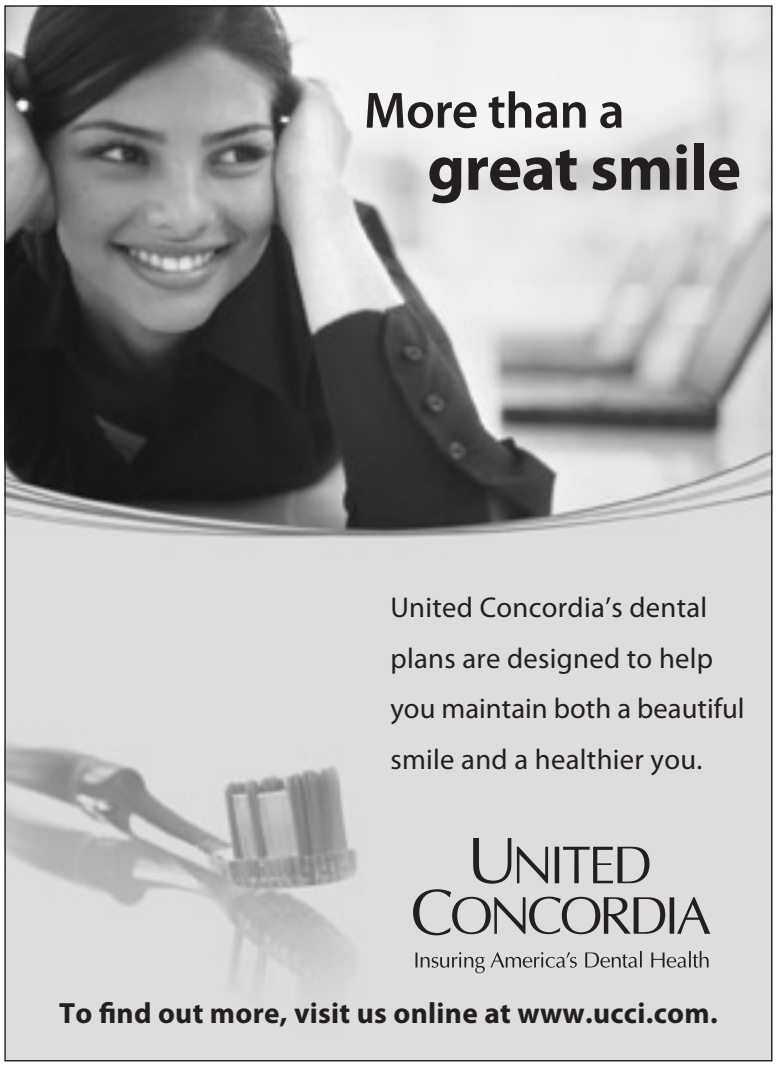
You and your dependents may consider enrolling in Concordia Flex, the dental plan from United Concordia. New for 2007 are enhanced benefits, designed to keep you smiling!

How the United Concordia Dental Plan Works

Through Concordia Flex, you have access to the Concordia Advantage Plus network of dentists, endodontists, periodontists, pedodontists, oral surgeons and orthodontists. With more than 83,500 dental locations nationwide and 660 dentist locations in New Mexico, a United Concordia network dentist is only a phone call or mouse click away.

The Concordia Flex plan also pays the same benefit level whether you use a network or a non-network provider. However, using a network dentist helps benefit your smile and your wallet since United Concordia providers cannot balance-bill and they file your claims for you.

NOTE: Effective, July 1, 2007, Concordia Preferred (Low Option) will no longer be available.



NEW *July 2007*

Did you know that a United Concordia dental plan offers even more in 2007? Check out the added benefits!

- ★ **Per person annual maximum now increased from $1,500 to $2,000!**
- ★ **Orthodontic coverage* now increased from 50% to 60%!**
- ★ **Orthodontic lifetime maximum* now increased from $1,200 to $1,500!**

PLUS

- ★ **Dental implant coverage at 50%!**

**Only applies to new treatment on or after July 1, 2007*

UNITED CONCORDIA
Insuring America's Dental Health

Dental Benefits At-A-Glance

This is a highlight of the benefits only. Refer to your member certificate or group subscriber agreement for specific details, including limitations and exclusions.

	Delta Dental of New Mexico	
	Delta Dental PPO Dentist	**Delta Dental Premier Dentist**
Annual Benefit Maximum (per plan year)	$1,500 per person	
Deductible	$50 per person, $150 family (lifetime max)	
Lifetime Orthodontic Benefit Maximum	$1,200 per person	
Diagnostic and Preventive Services		
Examples of Diagnostic and Preventive Services include: Cleanings, Exams, X-rays, Fluoride treatment, Sealants, Emergency treatment for the relief of pain	Plan pays 100% no deductible applies	Plan pays 80%, no deductible applies
Basic Services		
Examples of Basic Services include: Fillings, Stainless steel crowns, Root canals, Periodontics, Oral surgery, Prescription medications for dental related conditions	Plan pays 85% subject to deductible	Plan pays 85% subject to deductible
Major Services		
 Examples of Major Services include: Specified implant services, Crowns, Partial or complete dentures, Bridges	Plan pays 50% subject to deductible	Plan pays 50% subject to deductible
Orthodontic Services		
Diagnostic, active and retention treatment for adults and children	Plan pays 50%	Plan pays 50%

Benefit percentages shown above are based on the dentist's billed amount, subject to the Maximum Approved Fees for the applicable provider network. Additional out-of-pocket costs will apply to non-network providers.

Enrolled persons are entitled to a PRE-DETERMINATION OF BENEFITS anytime more costly procedures are anticipated. When requested by a dental provider, an advance estimate of benefits payable can be provided by Delta Dental before dental care services are received. Pre-determination is strongly recommended and there is no charge for this service.

This page of benefits highlights, which has been prepared for Open Enrollment and general benefit description purposes, does not include every type of covered service. It does not reflect plan provisions, including frequency or other limitations, and does not provide complete coverage information. Please refer to the Delta Dental Summary of Benefits and Dental Benefit Handbook.

	United Concordia
	Concordia Flex (High)
Annual Benefit Maximum (per plan year)	$2,000 per person NEW in 2007
Deductible	$50 individual, $150 family (lifetime max)
Lifetime Orthodontic Benefit Maximum	$1,500 per person* NEW in 2007
Diagnostic and Preventive Services	
Examples of Diagnostic and Preventive Services include: Cleanings, Exams, X-rays, Fluoride treatment, Sealants, Emergency treatment for the relief of pain	Plan pays 100% of allowable amount, no deductible applies[4]
Basic Services	
Examples of Basic Services include: Fillings, Stainless steel crowns, Root canals, Periodontics, Oral surgery, Prescription medications for dental related conditions	Plan pays 85% of allowable amount after deductible**
Major Services	
NEW in 2007 Examples of Major Services include: Specified implant services, Crowns, Partial or complete dentures, Bridges	Plan pays 50% of allowable amount after deductible
Orthodontic Services	
Diagnostic, active and retention treatment for adults and children	Plan pays 60% up to lifetime maximum NEW in 2007

[4]Flouride: 2 per year up to age 19. Sealants: permanent molars only.

*Only applies to new treatment plans on or after July 1, 2007.

**Amalgam fillings on posterior teeth. Composite resin fillings for anterior teeth only.

Vision Plan

Plan Benefits

The Vision Plan offers coverage for general vision benefits, such as exams, eyeglasses, and contact lenses. Read more about the plan benefits on the next page.

Keep in mind this information is a summary only, and you should refer to the plan's official Summary Plan Description for full details, including all limitations and exclusions.

Learn More

You can find more information at **http://eweb.cabq.gov/**

Your Choice

You may choose to enroll yourself and your eligible dependents in the Davis Vision Plan.

As a safeguard to protect the utilization of the Vision Plan, City of Albuquerque and participating entities have a 2-year enrollment requirement under this plan. You and each member of your family have to fulfill the 2-year enrollment requirement before you can drop vision coverage unless the member resigns, retires or terminates employment.

Cost of Coverage

When you enroll in the vision plan, you are responsible for part of the premium cost. The chart below shows your cost, which is taken on a per pay period basis. As you can see, your amount depends on what family members you enroll.

Bi-Weekly Contributions	
	Davis Vision Plan
Employee only	$0.40
Employee and spouse	$0.77
Employee and children	$0.81
Employee and family	$1.21

Davis Vision Plan

The Davis Vision Plan offers vision coverage throughout the state. Providers represent all types of vision specialists including: private optometrists, ophthalmologists, free-standing retail stores and optical centers located within national retail department stores.

How the Davis Vision Plan Works

When you use a Davis Vision provider, your vision benefit covers a comprehensive eye examination, lenses (spectacle or contacts) and a $40 wholesale allowance for frames.

In private offices, Davis Vision expands on the $40 wholesale frame allowance by providing access to the Tower Collection available at network doctor offices. This provides access to 300 more fashionable frames including unisex styles and gender-specific classics. Many come with a one-year unconditional breakage warranty.

When you use out-of-network providers, you will receive a reimbursement up to an allotted amount. You will need to complete a claim form and send it to Davis Vision for reimbursement.

Send to:
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

To request claim forms, visit www.davisvision.com or call 800-999-5431.

Call 800-999-5431 to find a network provider near you or access the directory online at www.davisvision.com.

Vision Benefits At-A-Glance

This chart is only a highlight of the benefits. Refer to your member certificate or group subscriber agreement for specific details, including limitations and exclusions.

	Network	Out-of-Network
Frequency		
Exam	Every 12 months	
Eyeglasses	Every 12 months	
Frames	Every 24 months	
Contact lenses	Every 12 months	
Exams	$10 co-pay	Reimbursement up to $35
Frames	$15 co-pay	Reimbursement up to $35
Lenses		
Single		Reimbursement up to: $25
Bifocal		$40
Trifocal		$55
Lenticular		$80
Contact lenses[2]		
In lieu of eyeglasses	No charge up to allowable amount[1]	Reimbursement up to $110
Medically necessary	No charge up to allowable amount[1] (prior approval required)	Reimbursement up to $210

Vision Plan Exclusions

The following items are not covered by this vision program:

- Medical treatment of eye disease or injury
- Vision therapy
- Special lens designs or coatings, other than those previously described
- Replacement of lost eyewear
- Non-prescription (plano) lenses
- Services not performed by licensed personnel
- Contact lenses and eyeglasses in the same benefit cycle
- Two pairs of eyeglasses in lieu of a bifocal

[1]To ensure maximum value for members, an exclusive contact lenses program has been developed to provide contact lenses at no co-pay for members when ordering the Davis Vision formulary lenses. The program supplements the plan design specified $110 allowance to ensure exceptional added value for contact lenses wearers. Under the program, members will receive one pair of standard soft daily wear contact lenses, two boxes of planned replacement contact lenses, or four boxes of disposable contact lenses. A $110 allowance, plus a 15% discount on any overage/balance, will be applied toward contact lenses from the provider's own supply (such as gas permeable or toric). When receiving services from a participating retail center, the allowance will be applied toward the purchase of contact lenses and fitting/follow-up fees. Where required by state law, the full allowance may be applied toward contact lenses only. Medically necessary contact lenses are covered in full (prior approval is required).

[2]Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses. Routine eye examination may include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.

Basic Life and AD&D Insurance

If you are an eligible permanent full-time or part-time employee, you are covered by the CIGNA basic life and accidental death and dismemberment (AD&D) plan. Your employer provides this coverage at no cost to you.

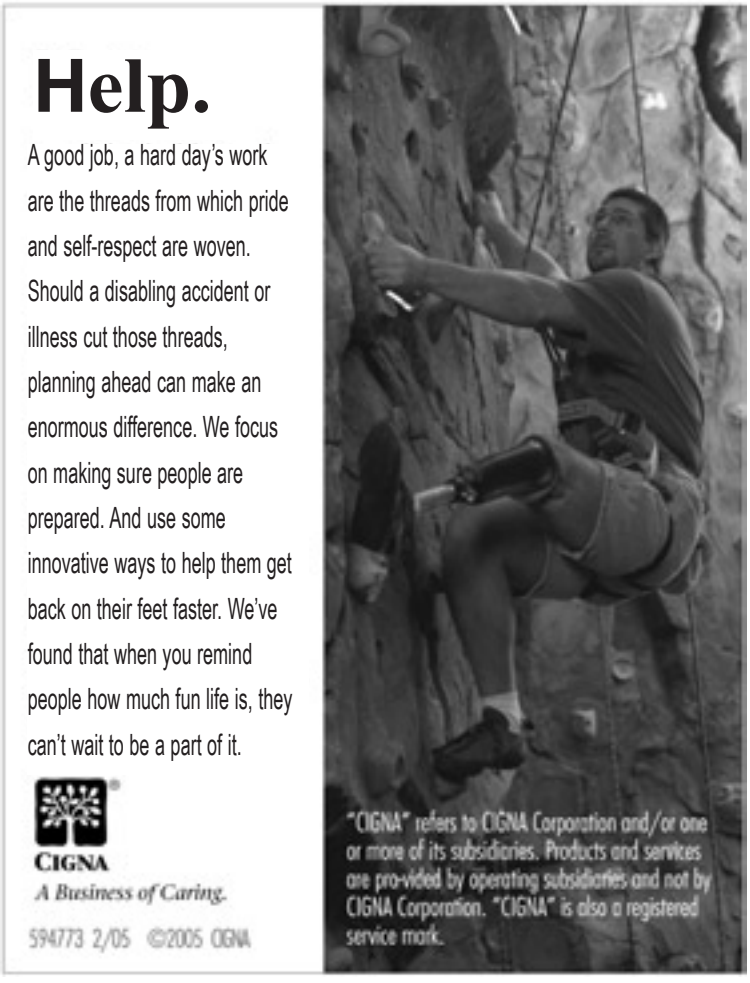
The plan will pay you a benefit based on your yearly compensation (see the table below) if you die, or a percentage of the benefit if you suffer a dismembering injury such as losing a hand, foot, or your eyesight.

CIGNA
A Business of Caring.

Your Yearly Compensation	Life Insurance Benefits	AD&D Benefits
Less than $5,000	$6,000	$6,000
$5,000 & less than $6,000	$8,000	$8,000
$6,000 & less than $8,000	$10,000	$10,000
$8,000 & less than $10,000	$12,000	$12,000
$10,000 & less than $12,000	$14,000	$14,000
$12,000 & less than $15,000	$17,000	$17,000
$15,000 & less than $20,000	$22,000	$22,000
$20,000 & less than $25,000	$28,000	$28,000
$25,000 & less than $30,000	$35,000	$35,000
$30,000 & less than $35,000	$40,000	$40,000
$35,000 & less than $40,000	$45,000	$45,000
$40,000 & over	$50,000	$50,000

Learn More

To learn more, call 505-768-3758.



Voluntary Life Insurance

If you would like to purchase additional life insurance protection for you or your dependents, you may do so through CIGNA's voluntary life insurance. You must be a full-time employee and work a minimum of 20 hours per week to be eligible. This plan is a voluntary plan, meaning if you participate you are responsible for the entire cost of the premium.

Voluntary Coverage for Yourself

You can buy coverage for yourself in increments of $10,000 up to $500,000. If you purchase an amount greater than $250,000 or increase coverage after initial eligibility, you will need to provide evidence of insurability. Death benefits will be reduced by 50% at age 70. And, your coverage ends when you retire.

If you become totally disabled before turning 60 years old, your coverage will remain in force without needing to pay premiums provided the insurance company approves you for this benefit. There is a nine-month waiting period and benefits will continue to age 65, as long as you remain totally disabled and provide proof each year. If you become terminally ill, you may receive 50% of your death benefit up to $250,000.

When you enroll in the voluntary life plan, you pay the premium cost through payroll deductions. The chart to the right shows your cost depending on your age and whether or not you smoke. Deductions are taken on a per pay period basis.

A sample contribution calculation

Employee *(age 28, non-smoker)*	*$250,000 ÷ 10,000 = 25 units* 25 units X $0.215 per unit	=	$5.38
Spouse/Domestic Partner *(age 24, smoker)*	$100,000 ÷ 10,000 = 10 units 10 units X $0.443 per unit	=	$4.43
Children	$10,000 benefit level	=	$0.96
	Total Bi-weekly Cost		**$10.77**

Additional AD&D Coverage

When you and/or your spouse/domestic partner enroll in voluntary life insurance you automatically receive additional AD&D coverage of $20,000.

Rate Per $10,000

Age	Smoker Rate	Non-Smoker Rate
Less than 30	$0.443	$0.215
30-34	$0.550	$0.275
35-39	$0.882	$0.443
40-44	$1.218	$0.658
45-49	$2.258	$1.271
50-54	$3.381	$1.880
55-59	$4.925	$2.709
60-64	$6.248	$3.486
65-69	$9.230	$5.198
70-74	$17.577	$9.786
75-79	$27.290	$15.194
80 and older	$65.573	$36.572

Voluntary Coverage for Your Dependents

If you decide to purchase coverage for your spouse/domestic partner, you may purchase coverage in increments of $10,000 up to $500,000, whether or not you purchase coverage for yourself. Rates are based on age. If you purchase an amount of dependent life coverage greater than the coverage amounts in the table to the right or increase coverage after initial eligibility, evidence of insurability will apply, which means you need to supply proof of good health which is acceptable to the insurance company.

Employee Coverage Amount	Spouse/Domestic Partner Coverage Guaranteed Amount
$50,000	$10,000
$100,000	$20,000
$150,000	$30,000
$200,000	$40,000
$250,000	$50,000

You can also enroll your children in the plan. Coverage starts for children at least 14 days old through age 25. You can purchase coverage in increments of $2,500 to a maximum of $10,000 for children six months to 25 years old. A $500 benefit is available for children 14 days to six months old.

Child Coverage Amount	Rate
$2,500	$0.240
$5,000	$0.480
$7,500	$0.720
$10,000	$0.960

Guarantee issue is available only at initial eligibility. All other requests for coverage are subject to underwriting approval. Rates for age 75 and over apply to active, full-time employees only. Spouse/domestic partner coverage ends at age 75. Suicide is excluded for the first two years of voluntary life coverage. Exclusions for the AD&D coverage will be listed in the enrollment brochures. This is a summary of group term life insurance coverage available under CIGNA Group Insurance. For specific provisions, please contact the City of Albuquerque Insurance Office (505-768-3758). Underwritten by Life Insurance Company of North America. This information is a brief description of the important features of the plan. It is not a contract. In the event of a discrepancy between this summary and the group insurance policy, benefits will be paid according to the terms and conditions of the policy. Please refer to your Life Insurance Company of North America brochure for a complete description of benefits, limitations and exclusions.

Long-Term Disability Coverage

The long-term disability (LTD) plan pays benefits if you become disabled for an extended period of time. If you are a full-time employee and you work a minimum of 20 hours per week, you may purchase LTD insurance through CIGNA. This plan is a voluntary plan, meaning if you participate you are responsible for the entire cost of the premium.

Your Age	Cost Per Dollar of Payroll
Less than 20	$0.00262
20-24	$0.00262
25-29	$0.00262
30-34	$0.00406
35-39	$0.00406
40-44	$0.00536
45-49	$0.00770
50-54	$0.01004
55-59	$0.01199
60-64	$0.01238
65 and older	$0.01238

A sample contribution calculation

Your salary = $32,000 at age 32

$32,000 divided by 26 pay periods = $1,231

$1,231 multiplied by $0.00406 (rate) = $5.00 per paycheck

Bi-weekly salary maximum is $3,846.

The LTD benefit provides you with income when you are unable to work for at least 90 days. Once you are disabled for 90 days of continuous disability, you will begin to receive disability benefits up to 60% of your eligible prior pay not to exceed $5,000 of benefits per month. (The minimum monthly benefit is $50.) The maximum amount may be reduced if you are receiving other sources of disability income from programs such as:

- Workers' compensation
- Social Security
- Another group disability or State disability plan
- A retirement plan, including PERA sponsored by your employer
- A dependent's coverage in which benefits are payable due to a covered person's disability
- Other government plans

If you are diagnosed with mental illness, drug or alcoholism benefits are limited to a 24-month lifetime maximum.

If you die while receiving benefits from the plan, a three-month sum will be paid to your beneficiary.

This plan contains a pre-existing limitation. This means that if you received medical treatment within three months before your coverage becomes effective, the plan will not pay benefits for a disability related to that condition. This limitation does not apply to a disability that begins after you are covered for at least 12 months after your coverage takes effect.

Definition of Disability

In order to receive benefits, you must be considered disabled under the plan, which generally means:

- **For the first 24 months of your disability,** you are not able to perform the duties of your own occupation and you are unable to earn more than 80% of your prior income.
- **After 24 months of disability,** you are not able to perform the duties of any occupation and you are unable to earn more than 60% of your prior income.

See the plan document for details, including limitations and exclusions.

Underwritten by Life Insurance Company of North America. A list of exclusions and limitations is included in the enrollment brochure. This information is a brief description of the important features of the plan. It is not a contract. In the event of a discrepancy between this summary and the group insurance policy, benefits will be paid according to the terms and conditions of the policy. Please refer to your Life Insurance Company of North America brochure for a complete description of benefits, limitations and exclusions.

Flexible Spending Accounts

You may choose to participate in one or both of the flexible spending accounts:

- Medical Care Reimbursement Account
- Dependent Care Reimbursement Account

These accounts are administered by BASIC, who holds your payroll deductions and makes reimbursements to you out of your account(s). You must complete the Flexible Benefit Plan Election/Change Form and the Direct Deposit Authorization Form (located on the back of the enrollment form) to participate.

The medical care reimbursement account lets you set aside tax-free-dollars for a wide range of health-related expenses that are not covered by the medical, dental or vision plans. You do not have to enroll in the medical, dental or vision plans to participate in this program.

The dependent care reimbursement account lets you set aside tax-free dollars for eligible day care expenses for your dependents.

For expenses to qualify:

- You and your spouse must be employed or actively seeking employment or attending school full time.
- Dependent care provider must claim payments as income.
- Dependent care expenses paid during a sick leave, holiday, or vacation are not eligible.
- Expenses must be for the care of a qualified person:
  - A child under 13 years old who is a dependent for income tax purposes. (If your child turns 13 during the plan year, expenses are no longer eligible for reimbursement.)
  - A spouse or dependent who is incapable of self-care and regularly spends at least eight hours per day in your home (i.e. an invalid parent). The same rules that apply for child care apply to the care of other dependents, except that the dependent need not be under age 13.

How the Accounts Work

First, you must incur an eligible expense. Then, you submit a Reimbursement Form and receipts to BASIC. You will receive the reimbursement through direct deposit if you complete the Direct Deposit Authorization Form. Since you are reimbursing yourself with "tax-free" dollars, you have more buying power than if you paid for the same expenses with after-tax dollars.

When you enroll, you need to decide how much you would like to contribute to your accounts each year:

- **For the medical care account,** the plan limit is $5,000 per eligible employee per year. If you and your spouse are employed by the City each can contribute $5,000.
- **For the dependent care account,** the maximum amount is $5,000 (married-filing jointly) or $2,500 (married-filing separately) each year.

You must carefully consider how much you would like to contribute. Because of the tax break, the IRS requires a "use it or lose it" feature for this benefit. That means if you have money left in your account at the end of the plan year, it will be forfeited.

You must enroll each year if you want to continue participating in the flexible spending account program.

B•A•S•I•C
Human Resource Connection
Western USA

Learn More

You can find more information at **http://eweb.cabq.gov/**

The dependent care account is a pay-as-you-go account. Your employer will not advance any money.

You should check with a tax advisor to see what your savings might be if you participate in the flexible spending account program.

Note that you are unable to use certain tax credits if you use the FSA accounts.

Federal regulations do not permit domestic partners to participate in the flexible spending accounts.

This is an example* of how you can save tax dollars with an FSA.

	With FSA	Without FSA
Annual income	$40,000	$40,000
Estimated health care expense	$3,500	$0
Taxable income	$36,500	$40,000
Estimated federal tax	$5,475	$6,000
Estimated Social Security tax	$2,792	$3,060
Healthcare expenses	$0	$3,500
Net pay	$28,233	$27,440
Savings with FSA	$793	N/A

*Based on 2007 federal income and Social Security taxes with standard deductions when filing married, jointly with two or more dependents.

Eligible FSA medical expenses include:

- Ambulance service
- Birth control
- Co-pays and deductibles
- Crutches
- Eye glasses
- Nursing care
- Medically prescribed physical therapy
- Orthodontics[1]
- Over-the-counter medicines such as pain relievers, antacids, allergy medicines and cold medicines[2]
- Smoking cessation programs, nicotine patches, and nicotine gum
- Special Needs[3]

For a comprehensive list of eligible expenses, visit www.irs.gov and search for IRS Publication No. 502.

Eligible FSA dependent care expenses include:[4]

- The costs for dependent day care, at home or in a day care center
- Nursery school expenses

For more information, visit www.irs.gov and search for IRS Publication No. 503.

Examples of ***ineligible health care expenses*** include Retin-A, weight loss programs, health club dues, diaper service, long-term care expenses.

Examples of ***ineligible dependent care expenses*** include transportation expenses, convalescent or nursing home expenses and overnight camp expenses.

Parking and Transit Plan (Section 132 Plan)

Now you can also save money on your transit costs (up to 40%) by joining the parking and transit program administered by BASIC.

You can pay for your work-related parking and mass transit costs with tax-free dollars. Because the City pays the administration fee, there is no cost to participate in this program.

How Much You Can Allocate Tax-Free?

The 2008 fiscal year limit for mass transit is $110 per month and $215 per month for parking.

Any unused funds continue to roll over month-to-month, year-to-year as long as you are an active employee.

Enrolling

City-Owned Lots:

You must complete the Parking Enrollment Form authorizing Payroll to convert your current deduction to a tax-free deduction.

Non-City Lots:

You must enroll online at www.basiconline.com Click on BASIC Parking. Click on submit expenses to complete the enrollment form.

To receive reimbursement for non-City lot parking, expenses must be submitted online at www.basiconline.com. You will receive your reimbursement by direct deposit only.

What Expenses Are Eligible

Your parking expenses on or near the premises of the City of Albuquerque or a location from which you commute to work by transit, van or carpool.

Parking/transit expenses resulting from travel to or from meetings, to visit other City departments, or other locations are ineligible for reimbursement.

[1]Reimbursement can only be made in accordance with the orthodontia contract, (e.g., monthly quarterly, etc). The orthodontia contract must be provided with each claim.

[2]These items must be purchased to alleviate or treat personal injury or sickness. Eligible items do not require a prescription. If the cash register receipt does not show the item description, a copy of the product packaging with price tag will be needed with the receipt.

[3]The service must be prescribed by a physician to treat a medical condition. Treatment cannot be for general health and/or well being.

[4]The services may be provided in your home or another location, but not by someone who is your minor child or dependent for income tax purposes (i.e. an older child).

- If the services are provided by a day care facility, that facility must comply with state day care regulations.
- Services must be for the physical care of the dependent, not for education, meals, registration, etc.
- Overnight camps and lessons in lieu of day care are not eligible for reimbursement from a dependent care account.

Supplemental Retirement Plans

'Your 457 Deferred Compensation Program'

Deferred Compensation seeks to provide the **"Extra"** money you need for a more enjoyable and comfortable retirement lifestyle.

What is Deferred Compensation?

- Voluntary, IRS-approved retirement savings plan
- Pre-Tax and Tax Deferred (Income taxes are due in the year in which the money is withdrawn)
- Deducted from paycheck

Contact your Plan Representative for more information.
Your Benefits Department offers these Deferred Compensation Providers:

ICMA RC
Building Retirement Security

Representative: **Steve Lopez**
Telephone: **(505) 842-8610**
Toll Free: **(800) 669-7400**
Email: slopez@icmarc.org

Representative: **Frank Morales**
Telephone: **(505) 892-2554**
Email: fmorales@icmarc.org

Representative: **Dennis Dexel**
Telephone: **(505) 899-5011**
Email: ddexel@icmarc.org

ICMA RC

Serving the following entities:

City of Albuquerque
Bernalillo County
Town of Bernalillo
Sandoval County

AIG VALIC
WE KNOW RETIREMENT.™

Representative: **Jeremy Mitchell**
Local: **(505) 830-4381**
Mobile: **(505) 263-4180**
Toll Free: **(800) 892-5558 x87607**
Email: jeremy_mitchell@aigvalic.com

VALIC

Serving the following entities:

City of Albuquerque
Bernalillo County
Sandoval County

Nationwide Retirement Solutions
a Nationwide® Financial company

Representative: **Sharon Peterson**
Telephone: **(505) 989-4992**
Toll Free Tel: **(866) 827-6639 x44418**
Fax: **(505) 989-4991**
Email: peters33@nationwide.com
Website: www.newmexico457dc.com

NATIONWIDE

Serving the following entities:

City of Albuquerque
State of New Mexico

Contacts and Resources

Employer

Office	Contact Name and Number
City of Albuquerque Insurance and Benefits Office 768-3758 City Hall 7th Floor, Room 702	Jan Gibson Human Resources Manager Insurance and Benefits 505-768-3758 (Fax) 505-768-3760
Santa Fe PERA Office	800-342-3422
Albuquerque PERA Office	505-883-4503
Santa Fe Retiree Health Care Office	800-233-2576
Albuquerque Retiree Health Care Office	505-242-0861

Insurance Companies

	Provider Group Number	Customer Service Web Site Addresses
Medical	Presbyterian GR1365	505-923-5678 or 1-800-356-2219 www.phs.org
	CIGNA 3327434	1-800-244-6224 www.cigna.com
Dental	Delta Dental 2517-0001	877-395-9420 505-855-7111 www.deltadentalnm.com
	United Concordia High Option 844614	800-332-0366 www.ucci.com
Vision	Davis Vision ABQ001	800-999-5431 www.davisvision.com
Life and AD&D Insurance	CIGNA (Basic) FLX980032 (Voluntary) FLX980018	800-238-2125, ext. 3406 www.cigna.com
Disability Coverage	CIGNA FLX980018-001 VDT960021-001	800-781-2006, ext. 6256 www.cigna.com
Supplemental Retirement Plans	AIG VALIC	505-263-4180 (Jeremy Mitchell) www.aigvalic.com
	ICMA	800-669-7400 Customer Service Dept. 505-842-8610 (Steve Lopez) 505-892-2554 (Frank Morales) 505-899-5011 (Dennis Dexel) www.icmarc.org
	Nationwide	866-827-6639, ext. 44418 Toll-free Customer Service 505-975-2784 (Sharon Peterson) Cell 505-989-4992 Santa Fe Office 505-989-4991 Fax www.newmexico457dc.com
Flexible Spending Accounts	BASIC Western 503	800-444-1922, ext. 1 www.basiconline.com
Parking/Transit Plan	BASIC Western	800-444-1922, ext. 220 www.basiconline.com

Human Resources Department
Patricia D. Miller, Director
768-3700

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